HEALTH REFORM - ADMINISTRATIVE SIMPLIFICATION

2009 GENERAL SESSION

STATE OF UTAH

LONG TITLE

General Description:

This bill modifies the Health Code and the Insurance Code to provide standards for the exchange of information between health care providers, health care insurers, and patients regarding payment for services.

Highlighted Provisions:

This bill:

- amends the timing of the requirement that a hospital send an itemized bill to a patient;
- creates a system wide, broad based demonstration project between health care payers and health care providers for innovating the payment and delivery of health care in the state;
- requires the Insurance Commissioner to convene health care insurers and health care providers to establish a more efficient coordination of benefits process;
- requires health benefit plans to issue to enrollees a standardized printed card containing health plan information;
- gives the Insurance Department rulemaking authority to establish standards for the electronic exchange of health plan information using card swipe technology which is compatible with national electronic standards;
- requires an insurer to provide information sufficient for a health care provider to determine the compensation or payment terms for health care services;
- requires the Insurance Commissioner to convene a group of health care insurers and health care providers to:
  - develop the use of standardized terminology and a standardized format of explanation of benefits so that a patient and health care provider can read and understand the explanation of benefits;

- create a more efficient and meaningful pre-authorization process; and
- create a consolidated and efficient health care provider health benefit plan credentialing process;

▸ prohibits an insurer from requiring less than one business day's notice of an emergency in-patient hospital admission; and

▸ amends the period of time in which an insurer can recover an amount paid to a health care provider when the insurer determines the payment was incorrect.

Monies Appropriated in this Bill:

None

Other Special Clauses:

None

Utah Code Sections Affected:

AMENDS:

26-21-20, as last amended by Laws of Utah 2000, Chapter 86

31A-22-619, as last amended by Laws of Utah 2001, Chapter 116

31A-26-301.6, as last amended by Laws of Utah 2007, Chapter 307

ENACTS:

31A-22-614.6, Utah Code Annotated 1953

31A-22-636, Utah Code Annotated 1953

31A-22-637, Utah Code Annotated 1953

Be it enacted by the Legislature of the state of Utah:

Section 1. Section **26-21-20** is amended to read:

26-21-20. Requirement for hospitals to provide statements of itemized charges to patients.

(1) For purposes of this section, "hospital" includes:

(a) an ambulatory surgical facility;

(b) a general acute hospital; and

(c) a specialty hospital.

[~~(1) Each hospital, as defined in Section 26-21-2,~~]

(2) A hospital shall provide a statement of itemized charges to any patient receiving

medical care or other services from that hospital.

[~~(2)~~] (3) (a) The statement shall be provided to the patient or [~~his~~] the patient's personal representative or agent at the hospital's expense, personally, by mail, or by verifiable electronic delivery [~~at the time any statement is provided to any person or entity for billing purposes.~~] after the hospital receives an explanation of benefits from a third party payer which indicates the patient's remaining responsibility for the hospital charges.

(b) If the statement is not provided to a third party, it shall be provided to the patient as soon as possible and practicable.

[~~(3)~~] (4) The statement required by this section:

(a) shall itemize each of the charges actually provided by the hospital to the patient[~~.~~];

(b) (i) shall include the words in bold "THIS IS THE BALANCE DUE AFTER PAYMENT FROM YOUR HEALTH INSURER", or

(ii) other appropriate language if the statement is sent to the patient under Subsection (2)(b); and

[~~(4) The statement~~] (c) may not include charges of physicians who bill separately.

(5) The requirements of this section do not apply to patients who receive services from a hospital under Title XIX of the Social Security Act.

[~~(6) A statement of charges to be paid by a third party and related information provided to a patient pursuant to this section~~]

(6) Nothing in this section prohibits a hospital from sending an itemized billing statement to a patient before the hospital has received an explanation of benefits from an insurer. If an insurer provides a statement of itemized charges to a patient prior to receiving the explanation of benefits from an insurer, the itemized statement shall be marked in bold: "DUPLICATE: DO NOT PAY" or other appropriate language.

Section 2. Section **31A-22-614.6** is enacted to read:

31A-22-614.6. Health care delivery and payment reform demonstration projects.

(1) The Legislature finds that:

(a) current health care delivery and payment systems do not provide system wide aligned incentives for the appropriate delivery of health care;

(b) some health care providers and health care payers have developed ideas for health care delivery and payment system reform, but lack the critical number of patient lives and

payer involvement to accomplish system wide reform; and

(c) there is a compelling state interest to encourage as many health care providers and health care payers to join together and coordinate efforts at system wide health care delivery and payment reform.

(2) (a) The Office of Consumer Health Services within the Governor's Office of Economic Development shall convene meetings of health care providers and health care payers through a neutral, non-biased entity that can demonstrate it has the support of a broad base of the participants in this process for the purpose of coordinating broad based demonstration projects for health care delivery and payment reform.

(b) Participation in the coordination efforts by health care providers and health care payers is voluntary, but is encouraged.

(3) The commissioner shall facilitate coordinated broad based demonstration projects for health care delivery and payment reform between various health care providers and health care payers who elect to participate in the demonstration projects by:

(a) consulting with health care providers and health care payers who elect to join together in a broad based reform demonstration project; and

(b) adopting administrative rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, as necessary to implement the demonstration project.

(4) The Office of Consumer Health Services and the commissioner shall report to the Legislature's Business and Labor Interim Committee by October 2009, and every October thereafter regarding the progress towards coordination of broad based health care system payment and delivery reform.

Section 3. Section **31A-22-619** is amended to read:

31A-22-619. Coordination of benefits.

(1) The commissioner shall:

(a) by July 1, 2009 convene a group of small and large group insurers and health care providers to develop a standardized and efficient method for coordination of benefits to increase the timeliness and accuracy of the coordination of benefits; and

(b) consider:

(i) determining which plan has primary responsibility when an individual is covered by two health care plans;

(ii) requiring health care plans with secondary responsibility to accept the medical necessity decisions of the primary health plan; and

(iii) requiring that health plans accept updated secondary payer information collected by providers at the time of service, rather than holding payment until they have obtained the information independently; and

(c) adopt rules concerning the coordination of benefits between accident and health insurance policies.

(2) Rules adopted by the commissioner under Subsection (1):

(a) may not prohibit coordination of benefits with individual accident and health insurance policies; and

(b) shall apply equally to all accident and health insurance policies without regard to whether the policies are group or individual policies.

Section 4. Section **31A-22-636** is enacted to read:

31A-22-636. Standardized health benefit plan cards.

(1) As used in this section, "insurer" means:

(a) an insurer governed by this part as described in Section 31A-22-600;

(b) a health maintenance organization governed by Chapter 8, Health Maintenance Organizations and Limited Health Benefit Plans;

(c) a third party administrator; and

(d) notwithstanding Subsection 31A-1-103(3)(f) and Section 31A-22-600, a health, medical, or conversion policy offered under Title 49, Chapter 20, Public Employees' Benefit and Insurance Program Act.

(2) In accordance with Subsection (3), an insurer must use and issue a standard health benefit plan information card for the insurer's enrollees upon the purchase or renewal of, or enrollment in a health benefit plan on or after July 1, 2010.

(3) (a) The requirements for the standard health benefit plan card shall be developed by administrative rule adopted by the department by July 1, 2009, in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

(b) The administrative rules adopted by the department shall require:

(i) the adoption of standardized terminology within which all health plans would be required to describe their plans, the benefits covered, the conditions for coverage, and the cost

sharing required;

(ii) the printed health benefit card to include:

(A) a standard format for the card;

(B) the covered person's name;

(C) the plan name;

(D) the contact information for the carrier or health benefit plan administrator;

(E) co-payments and deductibles for the most commonly used health care services; and

(F) an indication of whether the health benefit plan is regulated by the state.

(c) (i) The commissioner shall work with the Department of Health, the Health Data Authority, and with state and national organizations that are developing uniform standards for the electronic exchange of health insurance claims or uniform standards for the electronic exchange of clinical health records to determine:

(A) when the tools and technology exist to standardize the electronic exchange of insurance enrollment and coverage information between an insurer and a health care provider using card swipe technology or some other appropriate technology; and

(B) whether eligibility notification, pre-authorization, service notification, and retroactive denials can be transmitted electronically.

(ii) When the commissioner makes a determination that the electronic technology exists and is feasible to accomplish the tasks described in either Subsection (3)(c)(i)(A) or (B), the commissioner shall begin the rulemaking process under Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to:

(A) adopt standardized electronic interchange technology and tools for insurance enrollment cards to include the following information in a standardized format:

(I) enrollee basic identifying information;

(II) plan identification and contact information;

(III) plan type;

(IV) covered benefits;

(V) cost sharing requirements; and

(VI) administrative requirements that are a condition of coverage; and

(B) designate which information should be electronically exchanged.

Section 5. Section **31A-22-637** is enacted to read:

31A-22-637. Health benefit plan administrative simplification -- Access to payment methodology -- Standardization of explanation of benefits -- Efficient pre-authorization procedures -- Notice of admissions.

(1) For purposes of this section, "insurer" is as defined in Section 31A-22-636.

(2) An insurer shall provide the information required in Subsections (3) through (5) to a health care provider who contracts with the insurer.

(3) (a) Subject to Subsection (3)(b), an insurer shall provide information sufficient for the health care provider to determine the compensation or payment terms for health care services, including:

(i) the manner of payment, such as fee-for-service, capitation, or risk;

(ii) the fee schedule or procedure codes reasonably expected to be billed by a health care provider's specialty for services provided pursuant to the health insurance contract and the associated payment or compensation for each procedure code; and

(iii) the effect, if any, on payment or compensation if more than one procedure code applies to the service.

(b) (i) If the insurer is unable to include the information described in Subsection (3)(a), the insurer shall include:

(A) the methodology used to calculate any fee schedule, such as relative value unit system and conversion factor or percentage of billed charges, including, if applicable, the name of any relative value unit system, its version, edition, or publication date, any applicable conversion or geographic factor, and any date by which compensation or fee schedules may be changed by the methodology as anticipated at the time of contract; and

(B) the identity of any internal processing edits, including the publisher, product name, version, and version update of any editing software.

(ii) An insurer may provide access to the information required in this Subsection (3) through a website that allows a participating provider to determine the effect of procedure codes on payment or compensation before a service is provided or a claim is submitted.

(iii) If the entity contracting with the health care provider is not the payer and is unable to include the information described in this Subsection (3), then the contracting entity shall provide a readily available mechanism, such as a specific website address, that allows the health care provider to obtain that information from the insurer or payer.

(4) An insurer shall provide information regarding any product or network for which the health care provider is to provide services.

(5) An insurer shall provide the health care provider with a specific website address that contains the identity of the contracting entity or payer responsible for the processing of the health care provider's compensation or payment.

(6) (a) By May 15, 2009, the commissioner shall convene a group of small and large group health insurers and health care providers to develop administrative rules that:

(i) make it easier for patients and health care providers to read and understand an explanation of benefits from an insurer by:

(A) developing the use of standardized terminology and a standardized format for an explanation of benefits;

(B) including in the explanation of benefits how charges were adjusted to arrive at the paid amount and whether the insurer deviated from its published:

(I) codes;

(II) edits; or

(III) reimbursement methodologies;

(ii) make the pre-authorization process more efficient for health care providers, insurers, and patients; and

(iii) create a consolidated and streamlined process for establishing the professional competency and scope of practice credentials of health care providers for health plan networks.

(b) The commissioner shall adopt administrative rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, by January 1, 2010 that incorporate the standards developed under Subsection (6)(a).

(7) (a) An insurer shall not require a health care provider by contract, reimbursement procedure, or otherwise to notify the insurer of a hospital in-patient emergency admission within a period of time that is less than one business day of the hospital inpatient admission, if compliance with the notification requirement would result in notification by the health care provider on a weekend or federal holiday.

(b) Subsection (7)(a) does not prohibit the applicability or administration of other contract provisions between an insurer and a health care provider that require pre-authorization for scheduled in-patient admissions.

Section 6. Section **31A-26-301.6** is amended to read:

31A-26-301.6. Health care claims practices.

(1) As used in this section:

(a) "Articulable reason" may include a determination regarding:

(i) eligibility for coverage;

(ii) preexisting conditions;

(iii) applicability of other public or private insurance;

(iv) medical necessity; and

(v) any other reason that would justify an extension of the time to investigate a claim.

(b) "Health care provider" means a person licensed to provide health care under:

(i) Title 26, Chapter 21, Health Care Facility Licensing and Inspection Act; or

(ii) Title 58, Occupations and Professions.

(c) "Insurer" means an admitted or authorized insurer, as defined in Section 31A-1-301, and includes:

(i) a health maintenance organization; and

(ii) a third party administrator that is subject to this title, provided that nothing in this section may be construed as requiring a third party administrator to use its own funds to pay claims that have not been funded by the entity for which the third party administrator is paying claims.

(d) "Provider" means a health care provider to whom an insurer is obligated to pay directly in connection with a claim by virtue of:

(i) an agreement between the insurer and the provider;

(ii) a health insurance policy or contract of the insurer; or

(iii) state or federal law.

(2) An insurer shall timely pay every valid insurance claim submitted by a provider in accordance with this section.

(3) (a) Except as provided in Subsection (4), within 30 days of the day on which the insurer receives a written claim, an insurer shall:

(i) pay the claim; or

(ii) deny the claim and provide a written explanation for the denial.

(b) (i) Subject to Subsection (3)(b)(ii), the time period described in Subsection (3)(a)

may be extended by 15 days if the insurer:

(A) determines that the extension is necessary due to matters beyond the control of the insurer; and

(B) before the end of the 30-day period described in Subsection (3)(a), notifies the provider and insured in writing of:

(I) the circumstances requiring the extension of time; and

(II) the date by which the insurer expects to pay the claim or deny the claim with a written explanation for the denial.

(ii) If an extension is necessary due to a failure of the provider or insured to submit the information necessary to decide the claim:

(A) the notice of extension required by this Subsection (3)(b) shall specifically describe the required information; and

(B) the insurer shall give the provider or insured at least 45 days from the day on which the provider or insured receives the notice before the insurer denies the claim for failure to provide the information requested in Subsection (3)(b)(ii)(A).

(4) (a) In the case of a claim for income replacement benefits, within 45 days of the day on which the insurer receives a written claim, an insurer shall:

(i) pay the claim; or

(ii) deny the claim and provide a written explanation of the denial.

(b) Subject to Subsections (4)(d) and (e), the time period described in Subsection (4)(a) may be extended for 30 days if the insurer:

(i) determines that the extension is necessary due to matters beyond the control of the insurer; and

(ii) before the expiration of the 45-day period described in Subsection (4)(a), notifies the insured of:

(A) the circumstances requiring the extension of time; and

(B) the date by which the insurer expects to pay the claim or deny the claim with a written explanation for the denial.

(c) Subject to Subsections (4)(d) and (e), the time period for complying with Subsection (4)(a) may be extended for up to an additional 30 days from the day on which the 30-day extension period provided in Subsection (4)(b) ends if before the day on which the

30-day extension period ends, the insurer:

(i) determines that due to matters beyond the control of the insurer a decision cannot be rendered within the 30-day extension period; and

(ii) notifies the insured of:

(A) the circumstances requiring the extension; and

(B) the date as of which the insurer expects to pay the claim or deny the claim with a written explanation for the denial.

(d) A notice of extension under this Subsection (4) shall specifically explain:

(i) the standards on which entitlement to a benefit is based; and

(ii) the unresolved issues that prevent a decision on the claim.

(e) If an extension allowed by Subsection (4)(b) or (c) is necessary due to a failure of the insured to submit the information necessary to decide the claim:

(i) the notice of extension required by Subsection (4)(b) or (c) shall specifically describe the necessary information; and

(ii) the insurer shall give the insured at least 45 days from the day on which the insured receives the notice before the insurer denies the claim for failure to provide the information requested in Subsection (4)(b) or (c).

(5) If a period of time is extended as permitted under Subsection (3)(b), (4)(b), or (4)(c), due to an insured or provider failing to submit information necessary to decide a claim, the period for making the benefit determination shall be tolled from the date on which the notification of the extension is sent to the insured or provider until the date on which the insured or provider responds to the request for additional information.

(6) An insurer shall pay all sums to the provider or insured that the insurer is obligated to pay on the claim, and provide a written explanation of the insurer's decision regarding any part of the claim that is denied within 20 days of receiving the information requested under Subsection (3)(b), (4)(b), or (4)(c).

(7) (a) Whenever an insurer makes a payment to a provider on any part of a claim under this section, the insurer shall also send to the insured an explanation of benefits paid.

(b) Whenever an insurer denies any part of a claim under this section, the insurer shall also send to the insured:

(i) a written explanation of the part of the claim that was denied; and

(ii) notice of the adverse benefit determination review process established under Section 31A-22-629.

(c) This Subsection (7) does not apply to a person receiving benefits under the state Medicaid program as defined in Section 26-18-2, unless required by the Department of Health or federal law.

(8) (a) Beginning with health care claims submitted on or after January 1, 2002, a late fee shall be imposed on:

(i) an insurer that fails to timely pay a claim in accordance with this section; and

(ii) a provider that fails to timely provide information on a claim in accordance with this section.

(b) For the first 90 days that a claim payment or a provider response to a request for information is late, the late fee shall be determined by multiplying together:

(i) the total amount of the claim;

(ii) the total number of days the response or the payment is late; and

(iii) .1%.

(c) For a claim payment or a provider response to a request for information that is 91 or more days late, the late fee shall be determined by adding together:

(i) the late fee for a 90-day period under Subsection (8)(b); and

(ii) the following multiplied together:

(A) the total amount of the claim;

(B) the total number of days the response or payment was late beyond the initial 90-day period; and

(C) the rate of interest set in accordance with Section 15-1-1.

(d) Any late fee paid or collected under this section shall be separately identified on the documentation used by the insurer to pay the claim.

(e) For purposes of this Subsection (8), "late fee" does not include an amount that is less than $1.

(9) Each insurer shall establish a review process to resolve claims-related disputes between the insurer and providers.

(10) An insurer or person representing an insurer may not engage in any unfair claim settlement practice with respect to a provider. Unfair claim settlement practices include:

(a) knowingly misrepresenting a material fact or the contents of an insurance policy in connection with a claim;

(b) failing to acknowledge and substantively respond within 15 days to any written communication from a provider relating to a pending claim;

(c) denying or threatening to deny the payment of a claim for any reason that is not clearly described in the insured's policy;

(d) failing to maintain a payment process sufficient to comply with this section;

(e) failing to maintain claims documentation sufficient to demonstrate compliance with this section;

(f) failing, upon request, to give to the provider written information regarding the specific rate and terms under which the provider will be paid for health care services;

(g) failing to timely pay a valid claim in accordance with this section as a means of influencing, intimidating, retaliating, or gaining an advantage over the provider with respect to an unrelated claim, an undisputed part of a pending claim, or some other aspect of the contractual relationship;

(h) failing to pay the sum when required and as required under Subsection (8) when a violation has occurred;

(i) threatening to retaliate or actual retaliation against a provider for the provider applying this section;

(j) any material violation of this section; and

(k) any other unfair claim settlement practice established in rule or law.

(11) (a) The provisions of this section shall apply to each contract between an insurer and a provider for the duration of the contract.

(b) Notwithstanding Subsection (11)(a), this section may not be the basis for a bad faith insurance claim.

(c) Nothing in Subsection (11)(a) may be construed as limiting the ability of an insurer and a provider from including provisions in their contract that are more stringent than the provisions of this section.

(12) (a) Pursuant to Chapter 2, Part 2, Duties and Powers of Commissioner, and beginning January 1, 2002, the commissioner may conduct examinations to determine an insurer's level of compliance with this section and impose sanctions for each violation.

(b) The commissioner may adopt rules only as necessary to implement this section.

(c) The commissioner may establish rules to facilitate the exchange of electronic confirmations when claims-related information has been received.

(d) Notwithstanding Subsection (12)(b), the commissioner may not adopt rules regarding the review process required by Subsection (9).

(13) Nothing in this section may be construed as limiting the collection rights of a provider under Section 31A-26-301.5.

(14) Nothing in this section may be construed as limiting the ability of an insurer to:

(a) recover any amount improperly paid to a provider or an insured:

(i) in accordance with Section 31A-31-103 or any other provision of state or federal law;

(ii) within [~~36~~] 24 months for a coordination of benefits error; or

(iii) within [~~18~~] 12 months for any other reason not identified in Subsection (14)(a)(i) or (ii);

(b) take any action against a provider that is permitted under the terms of the provider contract and not prohibited by this section;

(c) report the provider to a state or federal agency with regulatory authority over the provider for unprofessional, unlawful, or fraudulent conduct; or

(d) enter into a mutual agreement with a provider to resolve alleged violations of this section through mediation or binding arbitration.